Piloting the Enhancing Care Program in the Adult Day Program Setting

Final Evaluation Report

March 2003

Prepared For: *Initiative #1 Work Group*
Staff Education and Training
Ontario's Strategy for Alzheimer Disease & Related Dementias

Prepared By: *Carrie A. McAiney, PhD*
Evaluation Consultant

Table of Contents

Executive Summary

The *Guidelines for Care* have been developed and endorsed by the Alzheimer Society of Canada (ASC) as ways to enhance the care provided by all caregivers in any caregiving situation. The Enhancing Care Program (ECP) is a multidisciplinary team-building process whereby an organization assesses how effectively it meets the eleven *Guidelines of Care*. Based on this assessment, the organization sets goals and develops an action plan, and process for monitoring goal achievement. To date, the ECP has been used in the LTC facility setting. The ASC and the Alzheimer Society of Ontario (ASO) believe that the ECP can be effective in other care settings, in particular, in Adult Day Programs (ADPs) that serve persons with Alzheimer Disease and related dementias.

As a result of support from Initiative #1, Staff Education and Training, of Ontario's Strategy for Alzheimer Disease and Related Dementias, a pilot project was undertaken to evaluate the applicability of the ECP in the ADP setting.

This is the final evaluation report from the pilot project. It includes the final recommendations regarding the applicability of the ECP in the ADP setting and also summarizes the results related to the impact of the ECP in the pilot sites.

Overall, the EC pilot was well received and valued by those involved. However, EC Team members, site coordinators and facilitators indicated that modifications were required to the rating scales in the EC Manual if the ECP was to be used with other ADPs.

The evaluation results also revealed that the ECP was considered to be a good way for staff to examine their programs in order to identify areas of strength and opportunities for improvement. As well, the program had a number of positive effects in the pilot sites.

The most significant impact was on staff (e.g., enhanced communication, increased awareness of the needs of clients with ADRD). EC Team members also reported benefits to family members of clients (e.g., enhanced means of communication between staff and families) but the family members who participated in the focus groups indicated that they had not noticed any changes within the day programs. Impacts on clients were likely to be indirect, resulting from the positive impact EC had on staff.

Based on these findings, a number of recommendations were made. The following section summarizes the recommendations that are being made to the Work Group for Initiative #1, Staff Education and Training, of Ontario's Strategy for Alzheimer Disease and Related Dementias.

Recommendations

Based on the results obtained from the evaluation of the pilot project, there was consensus that the ECP is appropriate for use in the ADP setting, but that some modifications are required. The recommendations related to these modifications include the following:

1. The rating scales within the EC Manual need to be modified to reflect the ADP situation.

2. A Task Group should be struck to review the items in the EC rating scales and determine whether the current scale items reflect the scope of care provided within ADP and to ensure that the appropriate terminology is used. The feedback provided in the manuals by the pilot sites will assist in identifying areas where changes may be required. However, this feedback was provided on an individual program basis and, therefore, may not reflect all ADPs across the province.

3. The Task Group should work toward coming to a consensus about the issue of "restraints" in ADPs.

4. Once the issue involving "restraints" has been resolved, additional information should be made available within the EC Manual to provide readers with an understanding of restraints within the ADP context.

5. The Task Group should also address the issues of: multidisciplinary, advance care planning, and abuse within the ADP context.

6. A "don't know" response option should be included in the rating scales.

7. During the training of the EC Facilitators, the issue of how to deal with "don't know" responses should be addressed.

8. Modify rating scale anchors where appropriate.

9. Multi-site ADPs should be provided an option of rating their sites separately for one or more of the Guidelines for Care during the assessment phase of the ECP.

A number of other recommendations were also made after Phase 1 of the pilot that are unrelated to the EC rating scales. These include:

10. The ECP is appropriate for all ADPs including dementia-specific and integrated programs provided that they serve at least some clients with dementia.

11. At least 10-12 hours is required to undertake the assessment and goal-setting components of the program.

12. The EC Team should include individuals that represent all perspectives in the ADP.

There were two other issues that were raised related to the implementation of the ECP in the ADP setting. These include the following:

- Time and funding are significant issues for ADPs. Because programs tend to be relatively small, there are no replacement staff available to fill in for staff who participate in this type of initiative. Consequently, staff must try to fit this in amongst their other responsibilities or undertake this on their own time.

- Given the constraints that ADPs face, the question that arises is "what is the incentive to participate in such a program?" Will this become part of the OCSA standards for ADPs?

10.0 Background

The *Guidelines for Care* have been developed and endorsed by the Alzheimer Society of Canada (ASC) as ways to enhance the care provided by all caregivers in any caregiving situation. The Enhancing Care Program (ECP) is a multidisciplinary team-building process whereby an organization assesses how effectively it meets the eleven *Guidelines of Care*. Based on this assessment, the organization sets goals and develops an action plan, and process for monitoring goal achievement. To date, the ECP has been used in the LTC facility setting. The ASC and the Alzheimer Society of Ontario (ASO) believe that the ECP can be effective in other care settings, in particular, in Adult Day Programs (ADPs) that serve persons with Alzheimer Disease and related dementias.

As a result of support from Initiative #1, Staff Education and Training, of Ontario's Strategy for Alzheimer Disease and Related Dementias, a pilot project is being undertaken to evaluate the applicability of the ECP in the ADP setting.

This is the final evaluation report from the pilot project. It includes the preliminary recommendations which came out of the first phase of the project (i.e., the assessment and goal-setting phase) as well as the final recommendations regarding the applicability of the ECP in the ADP setting, and the results related to the impact of EC in the pilot sites.

11.0 Overview of Project

The following provides a brief overview of the approach taken in this pilot project:

2.1 Design of the Pilot

The Evaluator, ASO, and ASC worked together to design the pilot in order to maximize the usefulness and generalizability of the results.

2.2 Selection of pilot sites

All ADPs funded by the Ministry of Health and Long-Term Care were invited to apply to be one of the six pilot sites for this initiative. The sites to be selected were to reflect, as much as possible, the range of ADPs in Ontario that serve persons with dementia. Selection of the pilot sites is discussed in Section IV.

2.3 Delivery of Enhancing Care (EC) in Pilot Sites

After the pilot sites were selected, the ADPs were asked to identify the members of their EC Team. It was suggested that individuals from different disciplines, or individuals who undertake different functions in the ADP, be included. The ADPs were also asked to identify an on-site coordinator who would assist the facilitator with the coordination and implementation of EC. The EC Team would then work with an EC facilitator from the local Alzheimer Chapter in undertaking the project.

There were two phases in this project: (i) Phase I - the initial assessment and goal-setting phase whereby the ADPs assess their ability to meet the *Guidelines for Care* and develop goals to enhance their program's ability to meet these guidelines and (ii) Phase II - implementation of the goals and monitoring goal achievement. Prior to the initiation of Phase I of the pilot, ASC made some slight modifications to the terminology used in the Enhancing Care Manual in order to make it more applicable to a broader range of settings.

2.4 Evaluation

An evaluation plan was developed to assess: (i) the applicability of the EC in the ADP setting and (ii) the impact of the ECP on the pilot sites. The evaluation plan is outlined in greater detail in Section III.

2.5 Recommendations Arising from the Pilot

After Phase I of the pilot (i.e., the assessment and goal-setting phase), a preliminary set of recommendations related to the applicability of the ECP for the ADP setting will be developed and shared with ASC for their review. The preliminary recommendations will then be shared with the Work Group for Initiative #1 of the Alzheimer Strategy in June 2002.

At the end of the pilot, the final evaluation report will be reviewed by the Task Group and submitted to ASC for consideration. The Task Group will then review the feedback from ASC and prepare the evaluation results and the feedback from ASC for submission to the Work Group for Initiative #1. This report will include the final recommendations related to the applicability of the ECP for the ADP setting and will provide results from the evaluation of the impact of EC on the pilot sites.

2.6 Development of Facilitators

A meeting will be held with all of the facilitators trained to provide Enhancing Care in Ontario in order to review the findings from the pilot and, if appropriate, prepare teaching materials and delivery strategies that reflect these findings.

12.0 Evaluation Overview

The primary goal of the pilot project is to determine whether the ECP can be implemented, in its current form, in the ADP setting. A secondary goal is to determine the impact of the ECP on the pilot sites.

Phase I of the project involves the following evaluation activities:

- completion of pre and post questionnaires by EC Team members;
- telephone interviews with facilitators and site coordinators; and
- information collected on the time spent working on the pilot and the types of activities undertaken by the facilitators and site coordinators.

In the second phase of the pilot project, the evaluation will include:

- administration of follow-up questionnaires for EC team;
- site visits to each ADP; and
- focus groups with (1) EC team members and (2) clients and/or family members.

As previously discussed, two evaluation reports will be submitted based on the outcomes from Phase I and Phase II of the pilot, respectively.

4.0 Selection of Pilot Sites and Facilitators

A list of all MOHLTC funded ADPs was obtained from the Ministry. A letter, short questionnaire, and background information on the ECP was sent to each of these ADPs. The letter explained the purpose of the pilot and invited the ADPs to indicate their interest in serving as pilot sites by completing the questionnaire enclosed. ADPs that were unable or unwilling to participate as possible pilot sites were also encouraged to complete the questionnaire. It was explained that this information would be used to characterize the ADPs in Ontario, and would thus aid in the selection process.

The selection criteria for the ADP pilot sites included the following:

- ADP receives funding from the MOHLTC;
- ADP has a significant focus on dementia;
- ADP is staffed by a mix of disciplines/functions;
- ADP is willing to participate and commit to the process;
- ADP is willing to participate in the evaluation process;
- ADP is culturally ready (i.e. able and willing) to make any necessary changes; and
- there is a trained Enhancing Care Facilitator (Alzheimer Society staff), who is willing to participate in this project and is available in the geographic area served by the ADP.

At the same time, letters and questionnaires were also sent to each of the Alzheimer Chapters across the province, requesting those who have been trained as EC facilitators to consider their participation in the pilot project. The questionnaires developed for the EC facilitators included questions about their experience and confidence in implementing the ECP, and asked them to identify ADPs in their area that might be good candidates for the pilot project.

The ADPs and facilitators were informed that those selected for the pilot would receive an honorarium for participating.

Information about the pilot project was sent to 140 ADPs across Ontario. Responses were received from 73 (52.1%) of the programs. Of these, 60 were interested and able to participate in the pilot project. From the 39 Alzheimer chapters, there were 19 individuals who were trained as EC facilitators and were able to participate in the pilot.

In order to select the pilot sites, the first step was to determine how many of the interested ADPs had EC facilitators in their areas who were also able to participate. Of the 60 ADPs, 40 had an available facilitator in their area. The information from the ADP questionnaires was then used to determine whether the ADPs met the other selection criteria. This information was also used to help select programs that would be representative of the ADPs across the province (e.g., the number of dementia-specific versus integrated programs). Using this information, together with the geographic location of the programs, the pilot sites were selected. The following table summarizes some of the characteristics of the sites selected.

Table 1: Overview of Pilot Sites

ID	City ADP is Located In	Region ADP is Located In	Type of Program	Comments
1	Windsor	Southwest	Dementia-specific	Included staff from 3 different sites; all sites are part of 1 ADP
2	Guelph	Central West	Dementia-specific	
3	Mississauga	Central West	Dementia-specific	
4	Barrie	Central East	Dementia-specific	
5	Pembroke	East	Dementia-specific (x1) Integrated (x2)	Included staff from 3 different sites; all sites are part of 1 ADP
6	Sault Ste. Marie	North	a) Integrated b) Dementia-specific	The 2 ADPs are run by different organizations. EC was implemented separately.

* Two of the ADPs are run by the local Alzheimer chapter. The specific ADPs are not indicated in the table in order to protect the programs' anonymity.

As indicated in the table, there were actually 7 ADPs selected to participate, although two of the programs were considered to be part of one "site". The idea of combining two separate sites came from a suggestion made by one of the ADPs. The suggestion was made because the program was concerned about their eligibility for the pilot, given the small number of staff employed. Since many of the ADPs across the province are relatively small, the selection committee thought it would be appropriate to include both programs within one site in order to determine the feasibility of delivering the ECP in this way.

One of the goals of the pilot was to determine whether the ECP could be used in both dementia-specific ADPs and integrated ADPs (i.e., ADPs that serve both dementia and non-dementia clients). As a result, during the selection process, the selection committee identified an equal number of dementia-specific and integrated ADPs to be included in the pilot. However, after the pilot was initiated, it was realized that the information used to determine which programs were integrated and which were dementia-specific was not always accurate. Thus, there were actually a greater number of dementia-specific programs in the pilot than integrated programs.

5.0 Logistics of Delivering EC

The ADPs were informed that Phase I of the pilot would require approximately 10 hours to complete. Scheduling of the meetings (including the number and length of the meetings, and when the meetings would be held) was to be determined by the facilitator and ADP. Table 2 summarizes information about the time spent in Team meetings.

Table 2: Information Related to the Delivery of Phase 1

ID	# of Team Members	# of Meetings	Length of Meetings	Total # of Hours Required for Meetings
1	6	3	4 hours each	12 hours
2	8	3	2 @ 4 hours 1@ 2 hours	10 hours
3 *	5	8	2 hours each	16 hours
4 *	5	5	4 @ 2 hours 1 @ 1.5 hours	9.5 hours
5	9	4	1 @ 2 hours 3 @ 3 hours	11 hours
6	a) 4 b) 6	a) 3 b) 4	a) 2 hours each b) 2 hours each	a) 6 hours b) 8 hours

*A person with dementia was included as an EC Team member.

Table 3 presents estimates of the time requirements for the EC Facilitators and Site Coordinators for the assessment and goal-setting phase of the pilot. For the Facilitators, the estimates include: time spent in meetings, preparation and coordination time, and other time spent in contact with the ADP. The estimated time requirements ranged from 10 to 33 hours, with an average of just over 20 hours. For the ADP site coordinators, the estimates include: time spent in meetings, coordination time, and other time spent in contact with the Facilitator. Estimates ranged from just over 11 hours to just over 25 hours, with an average time estimate of 17 hours.

Table 3: Time Requirements by EC Facilitator and ADP Site Coordinator

ID	Time Required by Facilitator (including time for meetings)	Time Required by Site Coordinator (including time for meetings)
1	23.25 hours	18.25 hours
2	25 hours	25.5 hours
3	33 hours	21 hours
4	14.75 hours	14.75 hours
5	23.5 hours *	16.25 hours
6	10 hours 14.5 hours	11.25 hours 12 hours
Average	20.6 hours	17 hours

* Note: Time does not include travel time; the ADP was a 2-hour drive each way. If travel was to be included in this estimate, the time required should be increased by 16 hours (i.e., a total of 39 hours).

6.0 Evaluation Results

6.1 Results from Pre and Post Questionnaires

This section provides a summary of the results from the pre and post questionnaires that were completed by the EC Team members. The results are provided for each pilot site as well as for all sites combined. However, caution must be taken in drawing site-specific conclusions because the results are based on a small number of cases.

The other issue to be aware of has to do with the wording of the questions in Tables 5-9 and the rating scale that was used for these questions. The EC Team members were provided with statements and asked to rate these statements on a 5-point scale, ranging from 1 = "strongly disagree" to 5 = "strongly agree". In most cases, if the ECP was rated in the most favourable way, a score of "5" would be given. However, for a few questions (e.g., "assessing all eleven guidelines at one time would be too much for most ADPs"and "there are too many objectives under each guideline to assess") a score of "1" would indicate a favourable score. Therefore, readers must consider the wording of individual questions when interpreting the results.

6.1.1 Response Rates

Table 4 summarizes the response rates for the pre and post questionnaires for each site.

The response rate was 100% for all sites on the pre-questionnaires. For the post questionnaires, only one individual did not complete a questionnaire.

Table 4: Response Rate for Pre and Post Questionnaires

ID	# of EC Team Members	Percent (& Number) who Completed the Pre-Questionnaire	Percent (& Number) who Completed the Post-Questionnaire
1	6	100% (6)	100% (6)
2	8	100% (8)	100% (8)
3	5	100% (5)	100% (5)
4	5	100% (5)	100% (5)
5	9	100% (9)	100% (9)
6	a) 4 b) 6	a) 100% (4) b) 100% (6)	a) 100% (4) b) 83.3% (5)
ALL	43	100% (43)	97.7% (42)

6.1.2 Support for Pilot Project

Prior to the initiation of the pilot project, EC Team members were asked to rate the level of support for the pilot project among three different groups: the EC Team members, other staff members (who were not part of the EC Team), and managers/administrators in the ADP. Support was rated on a 5-point scale (where 1 = "poor" level of support and 5 = "excellent" level of support).

The scores are reported in Table 5. Overall, support among EC Team members and ADP managers/administrators was rated as "very good". Support among other staff members was rated somewhat lower, between "good" and "very good".

Table 5: Perceived Support among EC Team Members, Other Staff & Managers/Administrators

ID	Average Support among EC Team Members	Average Support among Other Staff Members	Average Support among ADP Managers / Administrators
1	Mean: 4.00 SD: .63 Range: 3 - 5	Mean: 3.50 SD: .87 Range: 3 – 5	Mean: 3.80 SD: .84 Range: 3 – 5
2	Mean: 4.38 SD: .52 Range: 4 – 5	Mean: 4.25 SD: .46 Range: 4 – 5	Mean: 4.38 SD: .52 Range: 4 – 5
3	Mean: 4.33 SD: .58 Range: 4 – 5	Mean: 3.00 SD: 1.0 Range: 2 – 4	Mean: 4.67 SD: .58 Range: 4 – 5
4	Mean: 3.40 SD: .89 Range: 2 – 4	Mean: 2.63 SD: .48 Range: 2 – 3	Mean: 3.40 SD: .55 Range: 3 – 4
5	Mean: 3.78 SD: .67 Range: 3 – 5	Mean: 3.13 SD: .64 Range: 2 – 4	Mean: 3.63 SD: .74 Range: 3 – 5
6	Mean: 4.00 SD: .82 Range: 3 – 5 Mean: 4.25 SD: .50 Range: 4 - 5	Mean: 3.75 SD: .50 Range: 3 – 4 Mean: 4.00 SD: 1.0 Range: 3 – 5	Mean: 4.25 SD: .96 Range: 3 - 5 Mean: 4.20 SD: .84 Range: 3 – 5
ALL	Mean: 4.00 SD: .69 Range: 2 - 5	Mean: 3.51 SD: .83 Range: 2 - 5	Mean: 4.00 SD: .77 Range: 3 - 5

* Note: The post-questionnaires from site 6a had not been received at the time of data analysis.

6.1.3 Feedback on the Enhancing Care Program

After completing the assessment and goal-setting phase of the pilot, EC Team members were asked to provide feedback on various aspects of the ECP and the process used to implement the program. Table 6 summarizes the feedback related to the ECP itself. Team members were asked to rate each statement on a scale of 1 to 5 (where 1 = "strongly disagree" and 5 = "strongly agree").

Overall, the EC Team members in each of the sites agreed that the goals of the ECP and the pilot project were clear. However, there was less agreement related to the statements "The guidelines were easy to understand" and "The assessment tool (i.e., the rating scale completed for each guideline) was effective in evaluating this Adult Day Program".

The lower level of agreement on the latter two items was also reflected in the qualitative comments made in the post questionnaires. A number of the Team members indicated that the terminology was not appropriate to the ADP setting, and that they found certain terms confusing. Comments were also made about the assessment tool and the rating scale used in the assessments (see below for details).

These findings are also supported by the feedback obtained from the facilitators and site coordinators (see below) who indicated that the EC Team members had some difficulty with the terminology used in the guidelines and with the assessment tool.

Table 6: Feedback Related to the ECP

ID	Goals of EC were Clear to Me	Goals of Pilot Project were Clear to Me	Guidelines were Easy to Understand	Assessment Tool was Effective in Evaluating this ADP
1	Mean: 4.17 SD: .41 Range: 4 – 5	Mean: 4.17 SD: .41 Range: 4 – 5	Mean: 3.67 SD: .52 Range: 3 – 4	Mean: 3.50 SD: .84 Range: 2 – 4
2	Mean: 4.50 SD: .76 Range: 3 – 5	Mean: 4.63 SD: .52 Range: 4 – 5	Mean: 4.00 SD: .76 Range: 3 – 5	Mean: 2.57 SD: .98 Range: 1 – 4
3	Mean: 4.60 SD: .55 Range: 4 – 5	Mean: 4.20 SD: .45 Range: 4 – 5	Mean: 3.00 SD: 1.4 Range: 1 – 4	Mean: 2.00 SD: 1.0 Range: 1 – 3
4	Mean: 4.20 SD: 1.3 Range: 2 – 5	Mean: 4.20 SD: .84 Range: 3 – 5	Mean: 3.80 SD: 1.1 Range: 2 – 5	Mean: 4.00 SD: .71 Range: 3 – 5
5	Mean: 4.44 SD: .77 Range: 3 – 5	Mean: 4.56 SD: 1.0 Range: 2 – 5	Mean: 4.22 SD: .67 Range: 3 – 5	Mean: 4.33 SD: .87 Range: 3 – 5
6	Mean: 4.50 SD: .58 Range: 4 – 5 Mean: 3.80 SD: 1.1 Range: 2 – 5	Mean: 4.50 SD: .58 Range: 4 – 5 Mean: 3.60 SD: 1.1 Range: 2 – 5	Mean: 5.00 SD: 0 Range: 5 Mean: 4.00 SD: .71 Range: 3 – 5	Mean: 4.25 SD: .50 Range: 4 - 5 Mean: 3.90 SD: .89 Range: 3 – 5
ALL	Mean: 4.35 SD: .78 Range: 2 - 5	Mean: 4.33 SD: .78 Range: 2 - 5	Mean: 3.95 SD: .90 Range: 1 - 5	Mean: 3.51 SD: 1.1 Range: 1 - 5

6.1.4 The Process Used in Delivering the ECP

Tables 7 and 8 summarize the average ratings given by the EC Team members related to the process used to deliver the ECP.

There was less agreement among EC Team members regarding whether "assessing all eleven guidelines at one time would be too much for most ADPs" and whether "there were too many objectives under each guideline to assess". The EC Team members tended to agree that there was "sufficient time given to complete the EC process". However, there was less agreement among Team members when asked whether "more time to learn about the guidelines would have been beneficial". Overall, the EC Team members agreed that the "number of EC meetings" and the "length of these meetings" were appropriate.

Table 7: Feedback Related to the ECP Process

ID	Assessing all 11 Guidelines at One Time May be Too Much for Most ADPs	There were Too Many Objectives Under Each Guideline to Evaluate	Sufficient Time was Allotted to Complete this Process	More Time to Learn about Guidelines Would Have Been Beneficial	The # of Meetings Held to Complete this Process was Appropriate
1	Mean: 3.50 SD: 1.0 Range: 2 – 5	Mean: 2.40 SD: .89 Range: 2 – 4	Mean: 4.33 SD: .82 Range: 3 – 5	Mean: 2.50 SD: 1.2 Range: 1 – 4	Mean: 4.80 SD: .45 Range: 4 – 5
2	Mean: 3.00 SD: .76 Range: 2 – 4	Mean: 2.63 SD: .74 Range: 2 – 4	Mean: 3.75 SD: .46 Range: 3 – 4	Mean: 2.75 SD: 1.5 Range: 1 – 5	Mean: 3.87 SD: .35 Range: 3 – 4
3	Mean: 2.60 SD: .89 Range: 2 – 4	Mean: 2.00 SD: .70 Range: 1 – 3	Mean: 3.20 SD: 1.3 Range: 2 – 5	Mean: 3.40 SD: .89 Range: 2 – 4	Mean: 3.20 SD: 1.6 Range: 1 – 5
4	Mean: 3.60 SD: 1.1 Range: 2 – 5	Mean: 3.20 SD: .84 Range: 2 – 4	Mean: 3.80 SD: 1.1 Range: 3 – 5	Mean: 3.00 SD: .71 Range: 2 – 4	Mean: 4.00 SD: .71 Range: 3 – 5
5	Mean: 3.56 SD: 1.0 Range: 2 – 5	Mean: 2.67 SD: 1.1 Range: 1 – 5	Mean: 3.78 SD: 1.1 Range: 2 – 5	Mean: 3.63 SD: .74 Range: 3 – 5	Mean: 4.11 SD: .78 Range: 3 – 5
6	Mean: 4.00 SD: .82 Range: 3 – 5 Mean: 4.40 SD: .89 Range: 3 – 5	Mean: 2.00 SD: 0 Range: 2 Mean: 2.60 SD: 1.5 Range: 1 – 5	Mean: 3.75 SD: 1.89 Range: 1 – 5 Mean: 4.60 SD: .55 Range: 4 – 5	Mean: 3.25 SD: 1.50 Range: 2 – 5 Mean: 2.00 SD: .71 Range: 1 – 3	Mean: 4.75 SD: .50 Range: 4 - 5 Mean: 4.20 SD: .84 Range: 3 – 5
ALL	Mean: 3.47 SD: 1.0 Range: 2 - 5	Mean: 2.55 SD: .94 Range: 1 - 5	Mean: 3.88 SD: 1.03 Range: 1 - 5	Mean: 2.93 SD: 1.1 Range: 1 - 5	Mean: 4.10 SD: .88 Range: 1 – 5

Overall, the EC Team members agreed the "Team members treated each other as equals" in this process, that the process was "helpful in improving services in the ADP", that they would "participate again in this process", and that the "process was a good way to improve care to individuals with dementia".

The comments made by the EC Team members in the post-questionnaire also support these findings. Team members indicated that there were a number of benefits that have been realized (as well as benefits that they anticipate to occur) as a result of participating in this process. These include: recognizing the strengths within their programs; identifying opportunities for improvement; enhancing the quality of care provided to clients; and improving communication among those involved in the ADP (i.e., staff, management, volunteers, caregivers).

Table 8: Feedback Related to the ECP Process (cont'd)

ID	The Length of the Meetings was Appropriate	All Team Members Treated Each Other as Equals	Process was Helpful in Improving Services in this ADP	If this Process was Adopted by this ADP, I Would Participate Again	Process is a Good Way to Improve Care for those with ADRD
1	Mean: 4.50 SD: .55 Range: 4 – 5	Mean: 4.83 SD: .41 Range: 4 – 5	Mean: 4.67 SD: .52 Range: 4 – 5	Mean: 4.67 SD: .82 Range: 3 – 5	Mean: 4.83 SD: .41 Range: 4 – 5
2	Mean: 4.13 SD: .34 Range: 4 – 5	Mean: 4.88 SD: .35 Range: 4 – 5	Mean: 4.13 SD: .64 Range: 3 – 5	Mean: 4.56 SD: .73 Range: 3 – 5	Mean: 4.38 SD: .52 Range: 4 – 5
3	Mean: 4.20 SD: .84 Range: 3 – 5	Mean: 4.80 SD: .45 Range: 4 – 5	Mean: 3.75 SD: .96 Range: 3 – 5	Mean: 4.60 SD: .55 Range: 4 – 5	Mean: 4.00 SD: .71 Range: 3 – 5
4	Mean: 4.40 SD: .55 Range: 4 – 5	Mean: 4.40 SD: .89 Range: 3 – 5	Mean: 4.20 SD: .84 Range: 3 – 5	Mean: 4.80 SD: .45 Range: 4 – 5	Mean: 4.60 SD: .55 Range: 4 – 5
5	Mean: 4.11 SD: .78 Range: 3 – 5	Mean: 4.89 SD: .33 Range: 4 – 5	Mean: 4.67 SD: .71 Range: 3 – 5	Mean: 4.56 SD: .73 Range: 3 – 5	Mean: 4.56 SD: .73 Range: 3 – 5
6	Mean: 4.67 SD: .58 Range: 4 – 5 Mean: 4.20 SD: .84 Range: 3 – 5	Mean: 5.00 SD: 0 Range: 5 Mean: 4.80 SD: .45 Range: 4 – 5	Mean: 4.33 SD: .58 Range: 4 – 5 Mean: 4.40 SD: .55 Range: 4 – 5	Mean: 4.33 SD: .58 Range: 4 – 5 Mean: 4.00 SD: 1.2 Range: 2 – 5	Mean: 5.00 SD: 0 Range: 5 Mean: 4.40 SD: .55 Range: 4 – 5
ALL	Mean: 4.29 SD: .64 Range: 3 - 5	Mean: 4.81 SD: .46 Range: 3 - 5	Mean: 4.34 SD: .69 Range: 3 - 5	Mean: 4.54 SD: .74 Range: 2 - 5	Mean: 4.52 SD: .59 Range: 3 - 5

6.1.5 Facilitator and Site Coordinator

Overall, the Team members agreed that it was helpful to have someone from outside the ADP to facilitate the process, that the guidance provided by the facilitator was helpful, and that it was helpful to also have an on-site person to help coordinate the project. The results from these questions are found in Table 9.

Table 9: Feedback Related to the Facilitator and Site Coordinator

ID	Using an External Facilitator is Better than Having Someone Directly Associated with the ADP Lead the Process	The Guidance Provided by the Facilitator was Helpful	In Addition to the External Facilitator, Helpful to Have an On-Site Person as a Coordinator
1	Mean: 3.17 SD: 2.0 Range: 1 – 5	Mean: 4.50 SD: .84 Range: 3 – 5	Mean: 4.50 SD: .55 Range: 4 – 5
2	Mean: 4.88 SD: .35 Range: 4 – 5	Mean: 5.00 SD: 0 Range: 5	Mean: 5.00 SD: 0 Range: 5
3	Mean: 4.60 SD: .55 Range: 4 – 5	Mean: 5.00 SD: 0 Range: 5	Mean: 4.60 SD: .89 Range: 3 – 5
4	Mean: 4.80 SD: .45 Range: 4 – 5	Mean: 5.00 SD: 0 Range: 5	Mean: 4.60 SD: .55 Range: 4 – 5
5	Mean: 4.63 SD: .52 Range: 4 – 5	Mean: 4.89 SD: .33 Range: 4 – 5	Mean: 4.78 SD: .44 Range: 4 – 5
6	Mean: 4.67 SD: .58 Range: 4 – 5 Mean: 4.20 SD: .84 Range: 3 – 5	Mean: 4.25 SD: .50 Range: 4 – 5 Mean: 4.80 SD: .45 Range: 4 – 5	Mean: 4.25 SD: .96 Range: 3 – 5 Mean: 4.20 SD: .84 Range: 3 – 5
ALL	Mean: 4.41 SD: 1.0 Range: 1 - 5	Mean: 4.79 SD: .47 Range: 3 - 5	Mean: 4.60 SD: .62 Range: 3 - 5

6.1.6 Overall

When asked whether the ECP was feasible to use in an integrated day program and a dementia-specific day program, there was more agreement among EC Team members about the feasibility of using the ECP in a dementia-specific program (see Table 10).

Team members were also asked whether changes should be made to the ECP if it was to be implemented in other ADPs. The majority of EC Team members indicated that changes should be made. The types of changes included: making the terminology more applicable to ADPs (versus long-term care facilities); clarifying terms; making changes to the rating scale in the assessment tool; and increasing the size of the check boxes (particularly if persons with dementia are to be involved in the EC process). These issues are discussed in more detail in the following section as they were also identified as issues by the facilitators and site coordinators.

Table 10: Feedback Related to the Overall ECP

ID	Process would be Feasible to Use in an Integrated ADP	Process would be Feasible to use in a Dementia Specific ADP	Are any Changes Required if the ECP is to be Offered to Other ADPs?	
1	Mean: 3.67 SD: .52 Range: 3 – 4	Mean: 3.80 SD: 1.1 Range: 2 – 5	Yes No	50.0% (3) 33.3% (2)
2	Mean: 3.87 SD: 1.5 Range: 1 – 5	Mean: 4.63 SD: .52 Range: 4 – 5	Yes No	87.5% (7) 0
3	Mean: 2.80 SD: 1.5 Range: 1 – 5	Mean: 4.60 SD: .55 Range: 4 – 5	Yes No	100% (5) 0
4	Mean: 3.60 SD: .55 Range: 3 – 4	Mean: 4.00 SD: 0 Range: 4	Yes No	60.0% (3) 20.0% (1)
5	Mean: 4.56 SD: .53 Range: 4 – 5	Mean: 4.44 SD: .73 Range: 3 – 5	Yes No	66.7% (6) 33.3% (3)
6	Mean: 4.25 SD: .96 Range: 3 – 5 Mean: 4.40 SD: .55 Range: 4 – 5	Mean: 4.50 SD: 1.00 Range: 3 – 5 Mean: 4.40 SD: .55 Range: 4 – 5	Yes No Yes No	25.0% (1) 75.0% (3) 60.0% (3) 20.0% (1)
ALL	Mean: 3.93 SD: 1.0 Range: 1 - 5	Mean: 4.36 SD: .69 Range: 2 - 5	Yes No	53.5% (23) 37.2% (16)

6.2 Summary of Feedback from Facilitator and Site Coordinator Interviews

After the assessment and goal-setting component of the ECP was completed, telephone interviews were conducted with the EC facilitators and site coordinators in order to gather additional feedback on the use of the ECP in the ADP setting. Interview guides were developed to assist in soliciting the information of interest. The interviews were transcribed and then analyzed for themes. The following is a summary of the feedback obtained from these interviews.

6.2.1 Appropriateness of the ECP in the ADP Setting

All of the site coordinators and facilitators, as well as a majority of the EC Team members from all of the pilot sites, indicated that the ECP was appropriate to use in the ADP setting. However, individuals from all sites indicated that modifications to the ECP were required.

6.2.2 Modifications to the ECP

The modifications required for the ADP setting were of three types:

a) modifications to the terminology used
b) modifications to some aspects of the guidelines
c) modification to the assessment tool.

a) In terms of changes to the terminology, participants (including EC Team members, site coordinators and facilitators) indicated that the terms used were primarily geared toward long-term care (LTC) facilities and were often not appropriate for the ADP setting. As well, there were certain terms/concepts that were particularly challenging for some team members to understand in the ADP context (e.g., the concept of the multidisciplinary team). As a result, there was often misunderstanding of these areas which lead to variability in the scores obtained, additional time required to explain the concepts, and some frustration on behalf of Team members.

b) One other area requiring modification was in some of the actual guidelines since many of the participants felt that some aspects of the guidelines were not appropriate to ADPs (e.g., restraints, assessing support for caregivers). In some cases, Team members were reported as being insulted because certain questions were asked (e.g., questions related to the use of restraints).

The facilitators site coordinators indicated that the EC Team members had made extensive comments regarding these issues in the EC Manuals. The manuals are being submitted to ASC in August 2002.

c) With respect to the assessment tool, one issue was raised regarding the scale that is used as part of the assessment tool. Another concern involved the appropriateness of the overall assessment tool for all team members.

In terms of the scale used in the assessment tool, two issues were highlighted. First, some of the participants indicated that the scale (a 5-point scale ranging from "almost never" to "almost always") was not always appropriate for the questions being asked. It was suggested that in some cases, a scale ranging from "strongly disagree" to "strongly agree" may be more appropriate. The other issue related to the scale concerned having to provide a rating in situations where a team member could not provide an answer. When a team member did not know an answer, he/she would have to give the item a low score, which in many cases skewed the results and often frustrated the other team members since the final score did not accurately reflect the situation within the Day Program.

There was also a concern raised about the appropriateness of the assessment tool for all team members. The concern related to the terminology used, as well as the assumptions underlying the questions asked in the assessment tools. It was indicated that non-registered staff were not always able to answer all of the questions in the assessment tool, either because of the terminology used, or because it was based on information that was not necessary for the person to know (e.g., the need for maintenance staff to know how regularly clients are assessed). As a result, team members sometimes felt that their responses were of secondary importance to those of registered staff since they were not always aware of these details.

6.2.3 Dementia-Specific and Integrated ADPs

Overall, the participants reported that the ECP is appropriate for all ADPs, provided that they serve at least some clients with dementia. A few participants reported that it may be difficult for some ADPs to separate the dementia part of the program from the non-dementia part. However, others thought that many of the issues within the ECP are relevant to any ADP client (whether they have dementia or not).

Facilitators and site coordinators were also asked whether there would be any difference in implementing the ECP in ADPs run by an Alzheimer Chapter versus those not run by a Chapter. Overall, the facilitators and site coordinators reported that there would not be any difference, but suggested that those run by an Alzheimer chapter may be easier to persuade to participate, and would likely have more direct access to resources that they could draw upon.

6.2.4 Time Requirements

In terms of implementing EC, the facilitators and site coordinators reported that at least 10-12 hours was required to undertake the assessment and goal-setting components of the program. This time does not include preparation time or travel time.

6.2.5 The EC Team

Two of the issues raised during the planning of the pilot had to do with the size and composition of the ADP staff and what impact these issues would have on the implementation of the ECP. ADPs generally have small numbers of staff and those staff are not likely to represent a multitude of disciplines. During the telephone interviews, the facilitators and site coordinators were asked to comment on these issues.

Overall, the small number of staff members did not affect the site's ability to find participants for the pilot project. Teams ranged in size from 4 to 9 participants. However, for one of the programs that was particularly small, it was more difficult to get participants. In some cases, because there were only a small number of staff available in the program, it was not possible to backfill staff. Because of this issue, a number of the programs had to hold their meetings when the program was not running. In some cases this was also necessary to accommodate the schedules of family members, volunteers and/or clients who were participating in the process.

Despite these issues, the small size of the teams was considered beneficial to others. In these cases, the facilitators felt that the size of the team helped to facilitate conversation, and site coordinators thought it assisted with team dynamics (e.g., everyone was aware of the issues, any problems could be dealt with when they arose, etc.).

In terms of the composition of the ADP staff and, hence, the EC Team, this was not considered problematic by most facilitators and site coordinators. While many of the teams struggled with the term "multidisciplinary" during the assessment component of the project, most felt that by including volunteers, family members, and others involved with the ADP, that the various perspectives of the ADP were sufficiently reflected. Many of the facilitators and site coordinators also discussed the importance of including a family member on the team. The family members often had different views of the issues discussed which helped the other members of the team to the broader implications. Feedback from family members also helped to highlight where more communication was needed (e.g., in situations where family members were not aware of things that the other team members thought they should know).

6.2.6 Multi-Site Pilot Sites

A number of ADPs across Ontario have more than one site from which their programs are run. In two of the pilot sites selected, the ADPs included staff members from more than one of their ADP sites. In another pilot site, two ADPs run by two different organizations were included as part of one pilot site. In the former case, involvement of staff from multiple sites was generally not considered an issue. The only challenge that arose was when there were substantial differences from one site to another (e.g., in terms of environmental design). In these cases, the overall program may have warranted a particular rating, but participants wanted to give a different rating for individual sites.

In the case where two separate programs were included in one pilot site, the facilitator essentially ran two separate ECPs. There were both advantages and disadvantages in implementing the program in this way. In terms of disadvantages, the experience was quite time consuming for the facilitator. As well, the facilitator sensed that there was some competition between the two programs. This was likely a result of both programs being located in the same facility, and perhaps exacerbated by the fact that neither program was

running at full capacity and, therefore, were hoping to attract additional clients. One of the benefits of running two programs simultaneously was that the facilitator could share information with the programs about what worked and did not work in the other program. Because the ADPs were located in the same site, the team members and site coordinators were also able to share information with each other about their experiences. Overall, the facilitator believed that the advantages of running two simultaneous programs outweighed the disadvantages.

6.2.7 Involving the Person with Dementia

Two sites involved a person with dementia on their EC Team. The facilitators and site coordinators reported were both pros and cons in doing this. The main benefit was being able to obtain the client's feedback on the issues discussed. As well, in some cases, the client identified areas of concern that the other team members had not recognized as issues. Involving a client, however, meant that more time was needed to explain concepts and issues to the client. It also impacted on when the meetings could be held (i.e., they had to be held after the program since the clients attended the programs) and the length of the meetings (i.e., meetings more than 2-hours in length were too long for the client). The other issue was that certain aspects of the program sometimes overwhelmed and frustrated the client. This was particularly true for the goal-setting component of EC. The two settings that included clients felt there was significant benefit in involving a client. However, there are issues that need to be considered if a group is considering including a person with dementia in this type of activity.

Other pilot sites indicated that they had considered including a client with dementia on their teams, but most felt that their clients were too impaired to be able to participate.

6.3 Summary of Goals

Table 11 provides a summary of the goals identified by each pilot site. At the time of follow-up, many of these goals were fully implemented, but some were only partially implemented and others not at all.

Table 11: Summary of Goals by Site

Site 1:
1. To formulate a template for an individualized personal care plan to be used by the Day Program personnel (staff, volunteers and students).
2. To implement the use of a written personal care plan for each client.
3. To evaluate the effectiveness of an individualized care plan for clients based on personnel and caregiver response and client response.

Site 2:
1. A policy will be developed about on-call procedures.
2. A preliminary draft of an intake checklist will be developed (to ensure families are informed of program service).
3. Formalized process for part-time staff to obtain client information, pertinent for weekend and holiday attendance, to be communicated to staff.
4. Voice-mail system regarding client information established for part-time weekend staff (e.g., attendance, medication changes, behaviours and interventions and family issues).
5. All part-time staff listen to messages on voice-mail system.

Site 3:
1. All family members/caregivers will be informed about the new Assessment/Therapeutic Recreation service plan and new Communication Process.
2. To reduce staff burnout, staff will take scheduled breaks.
3. Staff will be knowledgeable about appropriate identification of elder abuse.
4. To create a formal recognition program for staff.
5. Create a supportive environment to support unscheduled breaks and time outs when needed.

Site 4:
1. Put locks on cupboards for chemicals, knives and other dangerous items.
2. Enhance the nametags for clients in the program to include contact phone number.
3. Information session/in-service for Red Cross drivers.

Site 5:
1. Increase volunteers in Day Program.
2. Enhance communication between staff and families.
3. To form a physical design committee to suggest changes to enhance programs/activities.
4. To enhance existing resources and ensure that learning is available in a timely and cost effective manner.
5. To hold regularly scheduled Planning Meetings for staff in order to develop new activities, evaluate existing ones and determine resources needed to carry out activities, and regularly scheduled Client Progress Meetings to assess clients' ongoing needs.
6. To hold regularly scheduled staff meetings in order to enhance team function.
7. To ensure a process of ongoing assessment is in place for dementia clients so that relevant programming will take place.
8. To pilot a Transportation Research Project to prove that with transportation provided, clients/families with dementia will benefit from Respite Service.

Site 6a:
1. To establish an in-house resource centre accessible to staff and family members.
2. Provide in-service to staff members on stress management.
3. Revise assessment tool.
4. Support group for family members

Site 6b:
1. Implementation of an orientation package for new family members.
2. Client information – daily report for families.
3. In-house library for clients, families and staff.

6.4 Results from Follow-Up Questionnaires: EC Team Members

6.4.1 Response Rate

In order to gain information on the implementation phase of the pilot project, as well as the impact of the pilot project overall, EC Team members were asked to complete a follow-up questionnaire. The overall response rate for this questionnaire was 93%. In site 4, the family member and client who were part of the EC Team did not feel they could complete the questionnaire because of their limited involvement in the implementation phase of the pilot project. There was only one other EC Team member who did not complete the questionnaire.

Table 12: Response Rate on Follow-Questionnaire - EC Team Members

Site ID	# of EC Team Members	Percent (& Number) who Completed Follow-up Questionnaire
1	6	100% (6)
2	8	100% (8)
3	5	100% (5)
4	5	60% (3)
5	9	100% (9)
6	a) 4 b) 6	75% (3) 100% (6)
ALL	43	93.0% (40)

6.4.2 Understanding of ADRD, ECP and the Guidelines in the EC Manual

The EC Team members were asked to rate their current level of understanding in 3 areas (i.e., Alzheimer disease and related dementias, the ECP, and the guidelines as stated in the EC Manual) using a 5-point scale (where 1 = "poor", 2 = "fair", 3 = "good", 4 = "very good" and 5 = "excellent"). Across all EC Teams, the average ratings were between 3 and 4 indicating that their understanding was between "good" and "very good" (see Table 13).

EC Team members had also been asked to rate their understanding of Alzheimer disease and other related dementias in the pre-pilot questionnaire. A comparison of the pre-pilot and follow-up scores indicated that there was an increase in their overall ratings (3.55 before the initiation of the pilot compared with 3.70 at follow-up); this difference approached statistical significance suggesting that the Teams' involvement in this pilot may have increased their understanding in this area.

Table 13: Understanding of Alzheimer Disease, the ECP and the Guidelines in the EC Manual by EC Team Members

ID	Current Understanding of Alzheimer Disease and Other Related Dementias	Current Understanding of the Enhancing Care Program	Current Understanding of the Guidelines in the EC Manual
1	Mean: 3.83 SD: .41 Range: 3 – 4	Mean: 3.83 SD: .41 Range: 3 – 4	Mean: 3.67 SD: .52 Range: 3 – 4
2	Mean: 4.38 SD: .74 Range: 3 – 5	Mean: 3.63 SD: .74 Range: 1 – 4	Mean: 3.38 SD: .74 Range: 2 – 4
3	Mean: 3.20 SD: .84 Range: 2 – 4	Mean: 4.00 SD: .71 Range: 3 – 5	Mean: 3.60 SD: .89 Range: 3 – 5
4	Mean: 3.67 SD: .58 Range: 3 – 4	Mean: 3.67 SD: .58 Range: 3 – 4	Mean: 3.00 SD: 1.00 Range: 2 – 4
5	Mean: 3.56 SD: 1.01 Range: 2 – 5	Mean: 3.78 SD: .67 Range: 3 – 5	Mean: 3.67 SD: .87 Range: 3 – 5
6	Mean: 3.33 SD: .58 Range: 3 – 4 Mean: 3.50 SD: .84 Range: 2 – 4	Mean: 3.67 SD: .58 Range: 3 – 4 Mean: 3.17 SD: .75 Range: 2 – 4	Mean: 3.67 SD: .58 Range: 3 – 4 Mean: 3.00 SD: .89 Range: 2 – 4
ALL	Mean: 3.70 SD: .82 Range: 2 - 5	Mean: 3.68 SD: .66 Range: 2 - 5	Mean: 3.45 SD: .78 Range: 2 - 5

6.4.3 Perceived Support among Team Members, Other Staff and Management

The EC Team members were also asked to rate the level of support for this pilot project among 3 groups: EC Team members, other ADP staff members, and ADP managers/administrators, using the same 5-point scale described above. The average ratings across all teams exceeded 4 or "very good" for the EC Team members and ADP managers/administrators groups. The average rating across all teams for support by other ADP staff was somewhat lower at 3.5, indicating that support among this group was between "good" and "very good" (see Table 14).

The EC Team members had also been asked to rate the level of support for this pilot among these 3 groups in the pre-pilot questionnaire. There were no statistically significant differences between the overall ratings prior to the pilot and at follow-up for any of the three groups, indicating that the level of support remained approximately the same throughout the pilot project.

Table 14: Perceived Support by EC Team Members among EC Team Members, Other Staff & Managers/Administrators

ID	Average Support among EC Team Members	Average Support among Other Staff Members	Average Support among ADP Managers / Administrators
1	Mean: 3.83 SD: .98 Range: 2 – 5	Mean: 3.80 SD: .84 Range: 3 – 5	Mean: 4.20 SD: .84 Range: 3 – 5
2	Mean: 4.25 SD: .46 Range: 4 – 5	Mean: 3.75 SD: .46 Range: 3 – 4	Mean: 4.50 SD: .54 Range: 4 – 5
3	Mean: 4.80 SD: .45 Range: 4 – 5	Mean: 3.40 SD: 1.14 Range: 2 – 5	Mean: 4.60 SD: .55 Range: 4 – 5
4	Mean: 4.00 SD: 1.00 Range: 3 – 5	Mean: 3.67 SD: .58 Range: 3 – 4	Mean: 2.67 SD: 1.53 Range: 1 – 4
5	Mean: 3.89 SD: .60 Range: 3 – 5	Mean: 3.13 SD: .84 Range: 2 – 4	Mean: 3.75 SD: .46 Range: 3 – 4
6	Mean: 4.00 SD: 0 Range: 4 Mean: 4.00 SD: .89 Range: 3 – 5	Mean: 3.00 SD: 1.00 Range: 2 – 4 Mean: 4.00 SD: 0 Range: 4	Mean: 4.67 SD: .58 Range: 4 – 5 Mean: 4.00 SD: .71 Range: 3 – 5
ALL	Mean: 4.10 SD: .71 Range: 2 - 5	Mean: 3.50 SD: .79 Range: 2 - 5	Mean: 4.11 SD: .84 Range: 1 - 5

6.4.4 Support Provided by the EC Facilitators

The EC Team members were asked to rate the level of support provided by the EC Facilitator during Phase 1 (the assessment and goal-setting phase) as well as Phase 2 (the implementation phase) of the pilot, using the same 5-point scale described above. The overall average ratings were 4.38 for Phase 1 and 3.94 for Phase 2 (see Table 15). While the average rating for Phase 2 of the pilot was lower than that for Phase 1, it should be noted that not all Facilitators were involved in the implementation of the EC Team's goals. In fact of the 5 facilitators who completed the follow-up questionnaire, only 1 Facilitator indicated that she was "very involved" in Phase 2 of the pilot. As well, the Facilitator for site 6 was on maternity leave during the implementation phase of the pilot, which may have lead to the lower ratings at this site.

Table 15: Perceived Support of the EC Facilitator by EC Team Members

ID	Support of EC Facilitator During Phase 1 of Pilot	Support of EC Facilitator During Phase 2 of Pilot
1	Mean: 4.33 SD: .82 Range: 3 – 5	Mean: 4.40 SD: .89 Range: 3 – 5
2	Mean: 4.62 SD: .52 Range: 4 – 5	Mean: 4.00 SD: .76 Range: 3 – 5
3	Mean: 5.00 SD: 0 Range: 5	Mean: 4.80 SD: .45 Range: 4 – 5
4	Mean: 4.67 SD: .58 Range: 4 – 5	Mean: 4.33 SD: .58 Range: 4 – 5
5	Mean: 4.00 SD: .71 Range: 3 – 5	Mean: 3.38 SD: .92 Range: 2 – 5
6	Mean: 4.00 SD: 1.00 Range: 3 – 5 Mean: 4.17 SD: .41 Range: 4 – 5	Mean: 3.00 SD: 1.41 Range: 2 – 4 Mean: 3.60 SD: 1.52 Range: 1 – 5
ALL	Mean: 4.38 SD: .67 Range: 3 - 5	Mean: 3.94 SD: 1.01 Range: 1 - 5

6.4.5 Impact on Quality of Care

When asked to rate the quality of care provided within their ADPs, the average ratings were relatively high, with average ratings across all teams exceeding 4 or "very good" (see Table 16).

Table 16: Average Ratings of Quality of Care by EC Team Members

ID	Quality of Care Provided in this ADP
1	Mean: 4.33 SD: .52 Range: 4 – 5
2	Mean: 4.63 SD: .52 Range: 4 – 5
3	Mean: 4.50 SD: .87 Range: 3 – 5
4	Mean: 4.67 SD: .58 Range: 4 – 5

5	Mean: 3.9 SD: .60 Range: 3 – 5
6	Mean: 4.33 SD: .58 Range: 4 – 5 Mean: 4.33 SD: .52 Range: 4 – 5
ALL	Mean: 4.34 SD: .61 Range: 3 - 5

In the follow-up questionnaire, Team members were asked if participating in this pilot project: (i) helped their program to better meet the needs of persons with Alzheimer disease and related dementias and (ii) had any impact on the quality of care provided by their program. These results are summarized in Table 17.

The EC Team members indicated that participation in the pilot project helped the programs to at least some extent, better meet the needs of persons with ADRD. The comments made in relation to this question are summarized in Table 18. Some participants reported that their program was better able to meet the needs of these clients as a result of specific activities they undertook as a result of the pilot (e.g., the implementation of care plans in one program and an orientation package in another program). Other participants indicated that the needs of clients were better met because of the positive impact the pilot project had on staff (e.g., enhanced communication, increased staff awareness of client needs).

When asked if participating in the pilot project had any impact on the quality of care provided within the ADP, the majority of participants (92.5%) said "yes" or "somewhat" (se Table 17). Identifying areas for improvement, improving communication, and reducing risk among clients were reported as examples of ways that quality of care had been improved (see Table 19).

Table 17: Impact of Participating in Pilot Project

Has participating in this pilot project …	Helped to Better Meet Needs of Person with ADRD?			Had an Impact on the Quality of Care that's Provided within the ADP?		
	Not at All	Somewhat	A Great Deal	No	Somewhat	Yes
Site 1	0	16.7% (1)	66.7% (4)	0	33.3% (2)	50.0% (3)
Site 2	0	25.0% (2)	75.0% (6)	0	25.0% (2)	75.0% (6)
Site 3	0	40.0% (2)	40.0% (2)	0	40.0% (2)	60.0% (3)
Site 4	0	33.3% (1)	66.7% (2)	0	66.7% (2)	33.3% (1)
Site 5	0	77.8% (7)	11.1% (1)	11.1% (1)	33.3% (3)	44.4% (4)
Site 6	0 0	33.3% (1) 50.0% (3)	66.7% (2) 50.0% (3)	0 0	66.7% (2) 33.3% (2)	33.3% (1) 66.7% (4)
ALL (N=40)	0	42.5% (17)	50.0% (20)	2.5% (1)	37.5% (15)	55.0% (22)

Table 18: Summary of Comments Made when Asked if Participating in the Pilot Project Helped the Program to Better Meet the Needs of Persons with ADRD

Specific Activities Undertaken: ▪ development and implementation of care plans ▪ development and implementation of orientation package ▪ initiation of library for staff, clients and families   ***Impact on Staff***: ▪ better communication among staff ▪ better communication between staff and clients ▪ increased staff awareness of issues related to the care of clients with Alzheimer disease and other dementias   ***Other***: ▪ many of our goals were staff related and not directed at clients ▪ unable to answer at this time since not all goals have been implemented

Table 19: Summary of Comments Made when Asked if Participating in the Pilot Project had any Impact on the Quality of Care Provided within the ADP

Impacts: ▪ identified areas for improvement ▪ better communication among staff results in more consistent care to clients and increased awareness of client and family needs ▪ reduced risk to clients   ***Other***: ▪ may not have had a significant impact but has set program on the right path, has opened the lines of communication, and given the staff an opportunity to focus on the program ▪ not enough time to see any noticeable changes

6.4.6 Recommendation for Other ADPs

When asked if they would recommend the ECP to other ADPs, 90% responded "yes"; the other 10% responded "perhaps". The ECP was cited as being an opportunity for programs to identify where they do well and where they need to improve. It was also reported to have a number of benefits to staff. The only qualifying statement that was made was that aspects of the ECP needed to be modified in order to be more applicable to ADPs (see Table 21).

Table 20: Recommendation of ECP to Other ADPs

Site	Would you Recommend the ECP to other ADPs?		
	No	Perhaps	Yes
1	0	0	100% (6)
2	0	12.5% (1)	87.5% (7)
3	0	20.0% (1)	80.0% (4)
4	0	33.3% (1)	66.7% (2)
5	0	0	100% (9)
6	0 0	0 16.7% (1)	100% (3) 83.3% (5)
ALL	0	10.0% (4)	90.0% (36)

Table 21: Summary of Comments Made when Asked Whether the EC Team Members would Recommend the ECP to Other ADPs

Comments related to the Benefits of the Program:

- provides an opportunity to identify what your program is doing well and how it can be improved
- enhanced staff morale, team building
- beneficial for accreditation purposes

Other:

- program needs to be modified so it is more applicable to the ADP setting

6.4.7 Other Comments

Other comments that were made about the ECP are summarized in Table 22.

Table 22: Other Comments about the ECP or the Pilot Project

- provided the program with an opportunity to reflect on the quality of the programs being offered
- good experience with some valuable changes made
- opportunity to learn more about the ADP and how it could be improved
- it was nice that staff were recognized for working in a stressful environment
- some changes required to the wording in the Manual to make it more applicable to day programs

6.5 Results from Follow-Up Questionnaires: EC Facilitators

Five of the 6 Facilitators completed the follow-up questionnaire. The Facilitator who did not complete the questionnaire was not able to do so because she was on maternity leave.

As was done with the EC Team members, the Facilitators were asked to rate the support for the pilot project among: ECT Team members, other ADP staff members and ADP managers and administrators using a 5-point scale (where 1 = "poor" and 5 = "excellent"). Average ratings in all three areas indicated that the level of support was "very good" or better (see Table 23).

In addition, Facilitators were asked to rate their ability to help the EC Team members: (i) understand the guidelines as stated in the EC Manual and (ii) understand how to apply the guidelines to the ADP setting. Overall, the Facilitators rated their ability in these areas as "very good" (see Table 23). A qualification made by one of the Facilitators was that she was not sure if the cognitively impaired client who participated as a Team member fully understood or was able to retain her explanations. Another Facilitator indicated that it was helpful to have an understanding of ADPs in order to help staff apply the guidelines to the ADP setting.

Table 23: Facilitator Ratings

How would you rate …	Mean (SD)
the support for this pilot project among the EC Team members?	4.40 (.55)
the support for this pilot project among other ADP staff?	4.00 (.00)
the support for this pilot project among ADP managers/administrators?	4.20 (.84)
your ability to help the EC Team members understand the guidelines in the EC Manual?	4.00 (.71)
your ability to help the EC Team members understand how to apply the guidelines to the ADP setting?	4.00 (.71)

When asked if the EC Team members had difficulty understanding or applying any terminology from the ECP, 3 Facilitators said they did and 2 said they did not (see Table 24). While 3 Facilitators indicated that Team members had difficulty understanding and/or applying terminology from the ECP, 4 Facilitators provided examples of the terminology Team members found challenging. Two Facilitators indicated that staff had difficulty understanding the "Restraints" guideline and how it applied to ADPs. Another facilitator indicated that the Team had difficulty with the concepts of "Assessing Decision Making: Respecting Individual Choice" and "assessment" in the ADP context. Another Facilitator reported that "non-staff" members had difficulty rating certain areas (e.g., transportation, assessment) because of their lack of knowledge in some aspects of the day program functioning.

Table 24: Difficulty with Terminology

Were there terms that the EC Team had difficulty understanding/applying?	Percent (& Number) of Facilitators
No	40.0% (2)
Yes	60.0% (3)

As indicated in Table 25, not all Facilitators were involved in assisting the EC Team implement their goals. In fact, only 1 Facilitator reported that she was "very involved" and none reported that they were "somewhat involved". Those who were not involved in this phase of the project indicated that the goals identified did not always require outside resources or intervention. As well, a number of the Facilitators reported that they were available to the Teams as a resource if required.

Table 25: Facilitator Involvement in Implementation of Goals

To what extent were you involved in assisting the EC Team with the implementation of their goals?	Percent (& Number) of Facilitators
Not at all	60.0% (3)
Only a Little	20.0% (1)
Somewhat Involved	0
Very Involved	20.0% (1)

When asked whether participating in the pilot project helped their ADP to better meet the needs of clients with ADRD, 3 Facilitators said it helped "a great deal" and 2 said it helped "somewhat" (see Table 26). Examples of how involvement in the pilot project helped to better meet the needs of this population are provided in Table 27. There was some overlap in the impacts identified by the Facilitators and those identified by EC Team members.

Table 26: Impact of Participation in Pilot Project – Facilitators

Has participating in this pilot project helped the ADP to better meet the needs of clients with ADRD?	Percent (& Number) of Facilitators
Not at All	0
Somewhat	40.0% (2)
A Great Deal	60.0% (3)

Table 27: Examples of How the Pilot Helped to Better Meet the Needs of ADRD Clients

Impact on Clients
- improved quality of support
- improved ADP environment

Impact on Staff
- enhanced communication among staff
- increased staff awareness of the needs of ADRD clients

Impact on Families
- encouraged more education about the program for families
- enhanced communication between staff and families

Impact on Program Overall
- assessment of program goals
- identification of strengths and areas requiring improvement
- refreshed policies and procedures

Four of the 5 Facilitators who completed the follow-up questionnaire said they would recommend the ECP to other ADPs; one Facilitator said that "perhaps" she would recommend the program (see Table 28). The comments made in relation to this question were generally very positive (see Table 29); although the Facilitators did indicate that some modifications to the EC Manual were required, and that the availability of backfill staff was likely to be a key issue in ADPs.

Table 28: Recommendation of the ECP – Facilitators

Would you recommend the ECP to other ADPs?	Percent (& Number) of Facilitators
No	0
Perhaps	20.0% (1)
Yes	80.0% (4)

Table 29: Comments related to the Question of Recommending the ECP to other ADPs

Benefits of ECP:
- a very positive experience
- an excellent product that goes beyond LTC
- re-energize staff; increase staff awareness of possibility for change
- enhance programs for clients and families
- great for revisiting policies and procedures and opening up dialogue with full and part time staff

Issues of Concern:
- some modifications in Manual required; not all issues are relevant to ADPs
- availability of backfill staff is a major concern; funding needed unless staff willing to participate on own time

The EC Facilitators were also asked what advice they would give to other EC Facilitators if they were to deliver the ECP to Other ADPs. A number of helpful suggestions were provided and are summarized in Table 30.

Table 30: Advice for Other EC Facilitators who Deliver EC to ADPs

- for ADPs that have multiple sites, Facilitators may want to separate the sites for the assessment part of the program since some aspects may be unique to one site or another (e.g., transportation issues may differ in urban and rural sites)
- reinforce the important role that family members and volunteers play as part of the team; actively engage them in the process
- be prepared to give specific examples of how the Guidelines for Care relate to day programs
- a non-threatening delivery – be a helped, not judgmental

Table 31 summarizes the other comments made by the EC Facilitators about the ECP pilot project.

Table 31: Other Comments made by EC Facilitators

- a wonderful experience; a pleasure to be part of this program
- Thank you for piloting this project within the ADP setting. ADPs are a critical part to the continuum of care for persons with dementia.
- I hope the ECP will be available for all interested ADPs.

6.6 Summary of Focus Group Findings

The final component of the evaluation of the pilot project involved focus groups with: (i) the EC Team members and (ii) family members of clients with ADRD. The purpose of the focus group and methods used, as well as a summary of the findings are presented below for each group.

6.6.1 Focus Groups with EC Teams

The purpose of the focus groups with the EC Team members was to obtain more detailed information on the implementation of the goals identified during the assessment and goal-setting phase of the project, as well as more information on the impact of implementing these goals. It was also used to clarify issues that were raised during the Phase 1 evaluation related to the applicability of certain aspects of the ECP in the ADP setting.

The focus groups were scheduled at times that were most convenient for the EC Team members. Seven focus groups were held with the EC Team members, one group for each pilot site. A total of 38 EC Team members participated, with groups ranging from 3 to 8 individuals.

A set of questions was used to guide the focus group discussion. Comments were recorded and later analyzed for common themes. The following provides a summary of the themes identified in the various areas addressed in the focus groups.

The ECP and EC Manual

During the Phase 1 evaluation, many of the EC Team members reported that while they were happy with the ECP, some aspects were not applicable to ADPs. This issue was explored further in the focus groups to determine whether it was the actual Guidelines for Care that the Team members were concerned about, or the items in the rating scales used to assess the Guidelines.

Overall, the focus group participants felt that it was a number of the rating scale items that were not applicable to their setting. All of the sites had provided feedback in their EC Manuals on the items they were concerned about. Examples of these items are found in Table 32.

Table 32: Examples of Items in the EC Manual's Rating Scales Considered Not Applicable to ADPs

Terms:	**Rating Scale Items**:
▪ multidisciplinary ▪ advance care planning ▪ assessment	▪ Families choose to be involved in the caregiving role at a level they are comfortable with. ▪ Every assessment is completed by members of a multidisciplinary team. ▪ Each person's activity plan emphasizes activities of daily living. ▪ Individual rooms have personal possessions / person can bring favorite possessions to program.

The most contentious issue identified by the pilot sites involved the "restraints" guideline. Many sites felt that this guideline was not applicable to ADPs; others were uncertain about what constituted a restraint in an ADP. It was suggested that more information about this issue and what it means in the ADP context was needed.

The focus group participants also identified some other issues of concern related to the rating scales.

Most sites indicated that they found it difficult to deal with situations where one or more members of the team did not know something and, therefore, were unable to respond to a question on the rating scale (e.g., whether staff members took breaks or could leave the program if they were feeling overwhelmed). When these individuals were forced to provide some type of rating, this skewed the overall results. Some focus group participants said that some of these questions appeared to exclude non-staff members because they did not have the knowledge to answer them. Participants suggested that a "don't know" response option be included for each scale item.

A few participants also noted that in some cases, the scale anchors did not match the question being asked.

Team Building

When asked if the ECP assisted with team building or enhanced communication, one site reported that team building was the primary outcome for them. Other sites indicated that communication among staff had improved as a result of the pilot. In ADPs where there was more than one site, participants reported being more informed of what was happening in the other sites. Some participants also reported that the pilot project experience helped to increase their understanding of different viewpoints, especially those of family members and volunteers.

Implementation Issues

During the focus group, some questions were asked to gain a better understanding of the process used to identify and develop goals. In terms of identifying goals, most participants said they used the results from their ratings to identify goals. A number of participants also reported that in going through the process, the areas that needed to be addressed were quite obvious. For some, 'time' was a factor that affected the goals that were selected since the sites were asked to develop goals that could be implemented within a 3-month period.

When asked about the use of the SMART principle in helping to develop goals, a few sites indicated that they did not use this principle. Participants from one program that did use this principle said that it helped them to develop goals that were realistic and measurable.

The EC Facilitator & Guidelines for Care

The focus group participants reported that the EC Facilitators had done an excellent job in helping them understand the Guidelines for Care. In most sites, the Facilitator was also able to help them understand how the guidelines could be applied to the ADP setting. Although in at least one site, if a particular issue seemed to have no application to ADPs, it was not discussed.

The participants were asked if more information about the Guidelines for Care would have helped them better understand the Guidelines. For most participants, reviewing the Guidelines before the project started was sufficient. For some, more education may have been helpful – particularly for family members and volunteers. Most groups emphasized that when going through this process there should be sufficient time to discuss the Guidelines.

Similar comments were made by the focus group participants when asked if more education would have helped them better understand how the Guidelines for Care applied to ADPs (i.e., most said the information they received was sufficient, although more education for family members and volunteers might be helpful). The one exception, however, was the Guideline on "Restraints". Participants said that more education about this Guideline and how it applied to ADPs would have been helpful.

In terms of learning about the Guidelines for Care, the focus group participants suggested that the small booklet on the Guidelines is used to introduce people to the area, and the EC Manual could be used for a more in-depth review.

Impacts of the Pilot Project

Focus group participants were asked a number of questions about the impact of the pilot project. Each of these is described below.

Participants were first asked what effects the implementation phase of the pilot project had on: ADP services or care, ADP staff, clients and caregivers. The most significant effects seemed to be on the ADP staff. Participants indicated that implementing their goals resulted in:

- increased awareness among staff of issues related to ADRD;
- an enhanced atmosphere among staff;
- improved communication among staff; and
- opportunities for staff education.

A number of impacts were also identified for caregivers, namely:

- increased communication/sharing of information between staff and families; and
- the initiation of family meetings in some programs.

For clients, the effects in most programs were indirect; that is, clients were likely to benefit because staff were more aware of their needs and were communicating better. Although in one program, increased safety for clients was identified as a direct effect on clients.

In terms of the effects on the service overall, many programs indicated that the project allowed them to look critically at their service. In one program, they also indicated that participation in the pilot helped to strengthen relationships between 2 ADPs and between their program and the Alzheimer Society.

As was done in the follow-up questionnaires, focus group participants were asked whether participating in the pilot project helped their program to better meet the needs of clients with ADRD. The responses provided were similar to those given in the questionnaires (e.g., participation resulted in increased awareness of client needs and enhanced communication among staff). The participants also indicated that ADPs need more resources to deal with the needs of clients and caregivers, and that they hoped these services would continue to be expanded.

The final question asked related to the impact of the pilot project, was whether participation in the project helped to increase the quality of care provided in the day program. Again, the types of responses provided were similar to those given in the follow-up questionnaire. In some cases, the participants said that it was too soon to tell (i.e., not all of their goals had been implemented, or there had not been sufficient time to determine if there was such an effect). Others said that there may have been an indirect impact on quality of care as a result of the impact the project had on staff.

Facilitators & Challenges

The focus group participants were asked what factors helped them to achieve their goals. They indicated that having great staff as well as a project working group, and being able to build on things they had already started, helped them with their goals.

The focus group participants also identified a number of challenges they faced in trying to achieve their goals. These included:

- Time: Because of the time constraints of the pilot project, this sometimes had an effect on the goals the Teams selected.
- Funding: ADPs are not funded for anything other than programming. Therefore, it was difficult to find time to undertake both the assessment and implementation phase of the project. It was particularly difficult to fit this into the workday in small programs. If this type of program was made available to other ADPs, participants said that staff may need to be paid for any overtime
- Timing: Trying to implement the goals over the summer (i.e., during summer holidays) was challenging.

Recommendation of ECP to Other ADPs

Focus group participants from all of the sites said that they would recommend the ECP to other ADPs. However, they also suggested that some of the wording in the EC Manual be changed to be more applicable to the ADP setting. They also re-emphasized the need to further explore the issue of "restraints" in the ADP context.

Other Comments

While the focus group participants were very positive about the ECP experience, they recognized that becoming involved in such initiatives can be a challenge for day programs. Participants at a number of sites asked about what incentive there was for ADPs to be involved in these types of initiatives (e.g., would it become part of accreditation an OCSA standard?).

6.6.2 Focus Groups with Family Members

The purpose of conducting focus groups with the family members of clients with ADRD was to determine whether they had noticed any changes in the day program as a result of the program's participation in the pilot project.

The Evaluator worked with each site coordinator to identify family members who would be willing and able to participate in the focus group. A letter which outlined the purpose of the focus group, the time commitment, and issues around confidentiality and voluntariness of participation was shared with potential participants (see Appendix A).

The groups were scheduled for times that were most convenient for most family members. A total of six family focus groups were held. In one pilot site, a family focus group was not held because at the time the focus group was conducted, this integrated ADP had only one client with dementia and thus, only one family member who could participate. This family member was also not available at the time the focus group with EC Team members was conducted because of other commitments. Consequently, there was no family member focus group for this site.

A set of questions was used to guide the focus group discussion. Comments were recorded and later analyzed for common themes.

The family focus groups revealed that the family members had not noticed any changes in the ADPs related to the ECP. The only exception was in cases where family members had participated as a member of the EC Team.

There are a few reasons why the family members may not have noticed any changes in the ADP. First, many of the goals developed by the EC Teams were not specific to family members and, therefore, it may not be realistic to expect families to see a change in the program. Second, enough time may not have passed for changes to be realized. Third, family members of ADP clients may have limited contact with the program and the staff and because their relatives are unlikely to be able to share a great deal of information about their time at the program because of their dementia, it may be unrealistic to expect them to notice any program changes.

Despite the lack of impact on family members, those participating in the focus group did comment on the quality of care provided within the programs and how happy they were to have their family members attending these programs.

7.0 CONCLUSION

The purpose of the pilot project was to determine: (1) whether the ECP could be implemented in the ADP setting in its current form and (2) the impact of the ECP on the pilot sites.

Overall, the EC pilot was well received and valued by those involved. However, EC Team members, site coordinators and facilitators indicated that modifications were required to the rating scales in the EC Manual if the ECP was to be used with other ADPs.

The evaluation results also revealed that the ECP was considered to be a good way for staff to examine their programs in order to identify areas of strength and opportunities for improvement. As well, the program had a number of positive effects in the pilot sites.

The most significant impact was on staff (e.g., enhanced communication, increased awareness of the needs of clients with ADRD). EC Team members also reported benefits to family members of clients (e.g., enhanced means of communication between staff and families) but the family members who participated in the focus groups indicated that they had not noticed any changes within the day programs. Impacts on clients were likely to be indirect, resulting from the positive impact EC had on staff.

Based on these findings, a number of recommendations were made. These are presented in the following section.

8.0 RECOMMENDATIONS

Based on the results obtained from the evaluation of the pilot project, there was consensus that the ECP is appropriate for use in the ADP setting, but that some modifications are required. The recommendations related to these modifications include the following:

8.1 Items that Comprise the Rating Scale

Overall, the pilot sites indicated that a number of items within the rating scales were not applicable to ADPs. Most sites identified the areas of concern in the comments they made in the EC Manuals.

Recommendations:

13. The rating scales within the EC Manual need to be modified to reflect the ADP situation.

14. A Task Group should be struck to review the items in the EC rating scales and determine whether the current scale items reflect the scope of care provided within ADP and to ensure that the appropriate terminology is used. The feedback provided in the manuals by the pilot sites will assist in identifying areas where changes may be required. However, this feedback was provided on an individual program basis and, therefore, may not reflect all ADPs across the province.

The most contentious issue identified by the pilot sites involved the "restraints" guideline. Many sites felt that this guideline was not applicable to ADPs. Others were uncertain about what constitutes a restraint in an ADP.

Other areas identified as being particularly challenging include the terms multidisciplinary/ interdisciplinary, advance care planning and abuse.

Recommendations:

15. The Task Group should work toward coming to a consensus about the issue of "restraints" in ADPs.

16. Once this has been agreed upon, additional information should be made available within the EC Manual to provide readers with an understanding of restraints within the ADP context.

17. The Task Group should also address the issues of: multidisciplinary, advance care planning, abuse within the ADP context.

8.2 Rating Scale Properties

- Most sites indicated that they found it difficult to deal with situations where one or more members of the team did not know some information and, therefore, were unable to respond to a question on the rating scale. When these individuals were forced to provide some type of rating, this skewed the overall results. As well, some questions appeared to exclude non-staff members because they did not have the knowledge to answer all questions.

Recommendations:

18. A "don't know" option should be included in the rating scales.

19. During the training of the EC Facilitators, the issue of how to deal with "don't know" responses should be addressed.

- In some cases, the scale anchors did not match the question being asked.

Recommendation:

20. Modify scale anchors where appropriate.

8.3 Other Scaling Issues

- For multi-site ADPs, it was sometimes difficult to provide one rating for all sites. Some of the processes/factors may be similar across sites, while others may be different.

Recommendation:

21. Multi-site ADPs will need to decide whether to rate their sites differently for some or all of the questions in the rating scales.

8.4 Other Issues

- Time and funding are significant issues for ADPs. Because programs tend to be relatively small, there are no replacement staff available to fill in for staff who participate in this type of initiative. Consequently, staff must try to fit this in amongst their other responsibilities or undertake this on their own time.

- Given the constraints that ADPs face, the question that arises is "what is the incentive to participate in such a program?" Will this become part of the OCSA standards for ADPs?

22. The ECP is appropriate for all ADPs including dementia-specific and integrated programs, provided that they serve at least some clients with dementia.

Overall, the participants reported that the ECP is appropriate for all ADPs, provided that they serve at least some clients with dementia. A few participants reported that it may be difficult for some ADPs to separate the dementia part of the program from the non-dementia part. However, others thought that many of the issues within the ECP are relevant to any ADP client.

Facilitators and site coordinators were also asked whether there would be any difference in implementing the ECP in ADPs run by an Alzheimer chapter versus those not run by a chapter. Overall, the facilitators and site coordinators reported that there would not be any difference, but suggested that those run by an Alzheimer chapter may be easier to persuade to participate, and would likely have more resources available to draw upon.

- At least 10-12 hours is required to undertake the assessment and goal-setting components of the program.

In terms of implementing EC, the facilitators and site coordinators reported that at least 10-12 hours was required to undertake the assessment and goal-setting components of the program. This time does not include any preparation time or travel time.

- The EC Team should include individuals that represent all perspectives in the ADP.

  Many of the participants discussed the value of involving individuals with different viewpoints in their discussions. There was also overwhelming support by participants from all sites regarding the value of including a family member as part of the EC Team because of the unique perspective they bring. In terms of involving the person with dementia, there was no consensus on this issue. Deciding whether to involve a person with dementia should probably be done on an individual basis, weighing the potential benefits and drawbacks.

APPENDIX A: Letter to Family Members regarding Focus Group

Fall 2002

Dear Family Member / Friend:

Over the past 6-7 months, staff from the _____ Adult Day Program have been participating in a pilot project involving the Enhancing Care Program. The Enhancing Care Program is an assessment process that was developed by the Alzheimer Society of Canada. The purpose of the Enhancing Care Program is to determine how well programs are doing in meeting and implementing the eleven principles of care for persons with dementia.

To date, the Enhancing Care Program has been used in long-term care facilities. This Day Program is one of 6 sites that is looking at whether the Enhancing Care Program is appropriate to use in the Adult Day Program setting.

We are also interested in finding out whether this program has made any difference for the individuals who attend this Adult Day Program and their family members. As a result, we are looking for family members of clients, who would be interested in participating in a focus group. The purpose of the focus group is to get a better understanding of your experience with this Day Program.

The focus group will be scheduled in October or November at a time that meets the needs of as many family members as possible. It will be approximately 1½ hours in length. At the focus group, I will be asking those who attend about the Day Program and their experience with the program over the past few months.

The focus group will be lead by myself, an evaluator from McMaster University. We will be using the feedback of family members from this Day Program along with the feedback from family members in the other Day Programs, to come up with some recommendations about the use of the Enhancing Care Program in the Adult Day Program setting.

No one participating in the focus group will be identified in any report or presentation. As well, whether you decide to take part in the focus group or not, the service that you and your family member receive in this Day Program will not be affected.

If you have any questions about the focus group, please feel free to contact _____ at the Day Program or me by telephone at 905-521-2100, ext. 74665 or by email at mcaineyc@mcmaster.ca.

Thank you for your time. I look forward to meeting with you in the near future.

Sincerely,

Carrie McAiney, PhD

ACKNOWLEDGEMENTS

There are numerous individuals and groups who contributed to this evaluation. I would like to thank the Alzheimer Society of Ontario, the Alzheimer Society of Canada, the Initiative #1 Work Group, and the representatives from the Ontario Ministry of Health and Long-Term Care who assisted with the development and implementation of the pilot project and its evaluation.

As well, sincere thanks are extended to Adult Day Programs that participated in the project including the staff members, family members and clients. Your time, support, and dedication are greatly appreciated.

I would also like to thank Kirstin Stubbing and Teresa Leung for their assistance with the administrative and data management aspects of the evaluation.

For further information or questions about the Alzheimer Strategy evaluation, please contact:

Carrie McAiney, PhD
Assistant Professor, Dept. of Psychiatry & Behavioural Neurosciences
McMaster University
&
Evaluator, Geriatric Psychiatry Service
St. Joseph's Healthcare Hamilton
Centre for Mountain Health Services
Email: mcaineyc@mcmaster.ca
Phone: (905) 388-2511, ext. 6722